CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PROVIDER

A participating provider is a pharmacy licensed by the Virginia Board of Pharmacy and having a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

PROVIDER ENROLLMENT

All providers of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

Providers must request participation agreements by writing, telephoning, or faxing their requests to:

First Health –VMAP-PEU	800-829-5373 - toll free in-state only
P.O. Box 26803	804-270-5105 - local to Richmond
Richmond, VA 23261-6803	804-270-7027 - FAX

An original signature of the individual provider is required. An agreement must be signed by the provider or by the authorized agent of the provider. Participating providers are required to complete new agreement forms when a name change or change of ownership occurs. For a sample Pharmacy Participation Agreement, see the exhibits at the end of this chapter.

Upon receipt of the signed agreement and supporting documentation, a seven-digit provider number will be assigned to each approved provider. **This number must be used on all claims and correspondence submitted to the Medicaid Program**.

Note: Provider identification numbers are specific to one physical location only. Providers must obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their participation agreements. Providers approved for participation in the Medicaid Program must perform the following activities as well as any

others specified by DMAS:

- Immediately notify the First Health Provider Enrollment Unit (FH/PEU), in writing, whenever there is a change in the information that the provider previously submitted. For a change of address, notify FH/PEU prior to the change and include the effective date of the change;

- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Ensure the recipient's freedom to reject medical care and treatment;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin;

- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;

- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency ...." The provider should not attempt to collect from the recipient or the recipient's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative. The provider may not charge DMAS or a recipient for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;

- Use Medicaid Program-designated billing forms for submission of charges;

- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided;

- In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid recipients; and

- Hold information regarding recipients confidential. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PARTICIPATION CONDITIONS

All pharmacies enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their provider agreements. A copy of a provider agreement form may be found at the end of this chapter. The paragraphs which follow outline special participation conditions which must be agreed to by pharmacies.

Requirements for pharmacy providers for participation include, but are not limited to:

- A license from the Virginia State Board of Pharmacy to operate in accordance with State statutes; drugs are to be dispensed by a pharmacist authorized to practice pharmacy under the laws of the state in which the applicant is licensed and practicing;

- Provision of services to Medicaid recipients without regard to race, color, religion, or national origin;

- Keeping of records necessary to fully disclose the extent of services provided to individuals receiving assistance under the State Plan;

- Provision of information to the DMAS as requested and access to records and facilities by personnel of the DMAS, the Office of the Attorney General, and federal personnel;

- Submission of claims for drugs dispensed to Medicaid recipients for reimbursement by Medicaid based on the pharmacy's usual and customary charge to the public not to exceed the upper limits established by DMAS;

- Medicaid participation is limited to providers who accept, as payment in full, the amounts paid by DMAS plus any deductible, copayment, or coinsurance required by the State Plan to be paid by the individual;
- Agreement to abide by Medicaid policies and procedures; and
- Allowance of freedom of choice in the selection of a provider service.

CERTIFICATION OF UNIT-DOSE DISPENSING

To be certified as a unit-dose provider to nursing facilities, the pharmacy should contact the Pharmacy Supervisor and request that certification information and forms be sent to the pharmacy. The address is:

Pharmacy Supervisor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

To be considered for certification, the pharmacy must submit the form, Unit-Dose Distribution Services (24-Hour Schedule), that describes the unit-dose system to be utilized, identifies the facilities and location of each, and identifies the unit-dose dosage forms. A certification statement must be signed by the pharmacy owner or official indicating agreement to meet the requirements and to provide a **prompt** (within 30 days) written notification to the Pharmacy Supervisor if there are any changes in the method of dispensing to the facilities.

Requirements for Certification

The requirements for certification are as follows:

- Each dose must be packaged individually;
- Each dose must be labeled identifying the drug and strength;
- Packaging/labeling must meet the requirements established by the State Board of Pharmacy for unit-dose dispensing;
- A 24-hour supply must be delivered on a daily schedule;
- A multiple-day dose (e.g., 7- to 30-day supply) **system** does **not** qualify for unit-dose certification.
- The facility must be identified as a nursing facility.
- Unit-dose dispensing to a home for the aged does **not** qualify for unit-dose certification.

REQUIREMENTS OF § 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for individuals with disabilities in the provider's programs or activities.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

Insurance Information

On paper claims, pharmacy providers are to disregard the information on billing primary insurance carriers for reimbursement in the drug program. The Insurance Company Codes (Exhibit III.6) and the Type of Coverage Codes (Exhibit III.7) in Chapter III do not apply to pharmacy providers when preparing claims for the dispensing of drugs. Bill primary insurance carriers only for durable medical equipment. For Instructions for Point-of-Service (POS) submission, see page 21 in Chapter IV.

Workers' Compensation

No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.

Liability Insurance for Accidental Injuries

The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in § 8.01-66.9 of the Code of Virginia.

When the provider bills and accepts payment by Virginia Medicaid in liability cases, the provider, under federal regulations, must accept Virginia Medicaid payment as payment in full; however, providers can initially choose to bill the third-party carrier or file a lien in lieu of billing Virginia Medicaid.

DOCUMENTATION OF RECORDS

The provider agreement requires the provider to maintain records that fully disclose the services provided to Medicaid recipients. Pursuant to federal law [42 CFR § 440.120(a)(2)], Medicaid can only provide payment for drugs dispensed by a licensed pharmacist in accordance with the State Medical Practice Act. In Virginia, this means that Medicaid can provide payment only for prescribed drugs dispensed and documented in

accordance with the Drug Control Act and the Board of Pharmacy Regulations. Documentation supporting Medicaid claims must be maintained for a minimum of five years. The following elements constitute Medicaid policy regarding documentation.

Original Prescriptions

Original prescriptions must include the following information:

- Name and address of the recipient receiving the service;
- Name and address of the prescriber;
- Prescription number, name, strength, and quantity of the drug dispensed;
- Directions for use;
- Date dispensed and initials of the dispensing licensed pharmacist; and
- "Brand Necessary" in the prescriber's handwriting on the face of the prescription, when required.

  NOTE: The "Brand Necessary" documentation requirement also applies to telephoned prescriptions. Prescribers must provide a paper copy to the pharmacist for file documentation.

Prescription Refills

Refills of prescriptions must include the following information on the back of the prescription:

- The refill date and initials of the dispensing licensed pharmacist;
- The quantity dispensed, if different from the face amount; and
- A notation of the refill authorization by the prescriber, if different from that on the face of the prescription.

Automated Records

In lieu of maintaining refill documentation on the back of the prescription, pharmacies with an automated data processing system must have on-line retrieval (via CRT display or hard-copy print-outs) documenting the following:

- The prescription number, name, strength, and quantity of the drug dispensed;
- The refill date and code or initials of the dispensing licensed pharmacist;
- The total number of refills authorized by the prescriber and the balance number

of refills remaining;

- The name of both the recipient and the prescriber; and
- The address of both the recipient and the prescriber, if not on file elsewhere in the pharmacy.

Records of Dispensing to Nursing Facilities

Physician orders must be on file for each drug dispensed for a recipient residing in a nursing facility.

Non-Unit-Dose

Non-unit-dose packaged drugs provided to the facilities by either unit-dose certified pharmacies or non-unit-dose pharmacy providers are to be documented in the prescription records as described above or in a patient profile as described below for unit-dose.

Unit-Dose

In lieu of the foregoing described documentation, certified unit-dose pharmacies claiming additional reimbursement for unit-dose dispensing must maintain records (patient profiles) which include the following information:

- The name and address of the recipient receiving the service;
- The name of the prescriber and his or her address, if not available elsewhere in the pharmacy;
- The prescription number, name, strength, and quantity of the drug dispensed;
- The directions for use; and
- Documentation on a daily basis of the delivery of a 24-hour supply of each drug.

Non-Legend Drugs

Documentation requirements described above apply to both legend and covered non-legend (Over-The-Counter) drugs.

Discontinued Drugs

Pursuant to the Board of Pharmacy regulations, records must show dispensed medications, which have been discontinued and not administered to the patient, as having been returned to the pharmacy. Billing records must reflect an adjustment in payments where appropriate.

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and to FHS-PEU thirty (30) days prior to the effective date. Such action precludes further payment by DMAS for services subsequent to the date specified in the termination notice. Notice should be sent to these addresses:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health –VMAP-PEU
P.O. Box 26803
Richmond, VA 23261-6803

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration of the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 2.2-4000 et seq.)) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment

schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to Section 32.1-313.1 of the Code of Virginia. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he or she has access to the publications as a part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

EXHIBITS

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COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services
Medical Assistance Program

PHARMACY PARTICIPATION AGREEMENT

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	**PAYMENT/CORRESPONDENCE ADDRESS**	**PHYSICAL ADDRESS** (***REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS***)
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this day of , agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. The pharmacy has obtained a license to operate from the State Board of Pharmacy in accordance with state statutes and drugs are dispensed by a pharmacist authorized to practice pharmacy under the laws of the state in which the applicant is licensed and practicing.
2. Services will be provided without regard to race, color, religion, or national origin. No handicapped individual shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 §USC 794) VMAP.
3. The pharmacy agrees to keep such records as VMAP determines necessary. The pharmacy will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General or his authorized representatives, and federal personnel will be permitted under reasonable request.
4. The pharmacy agrees that claims submitted will be based on the pharmacy's usual, customary charge and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims. Reimbursement may not exceed the upper limits established by VMAP.
5. Payment by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered by VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited and may subject the provider to federal or state prosecution.
6. The applicant agrees to pursue all other third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The pharmacy agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
9. This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For FIRST HEALTH's use only

Director, Division of Program Operations Date

For Provider of Services:

Pharmacy Name

Original Signature of Provider **Date**

_____City or _____County of

IRS Identification Name (required)

IRS Identification Number **(Area Code) Telephone Number**

mail **one** completed **original** agreement to: **FIRST HEALTH - VMAP-Provider Enrollment Unit**
PO Box 26803
Richmond, Virginia 23261-6803

Pharmacy License Number

Medicare Carrier and Vendor Number

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87

First Health Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

- ☐ **COMPUTER GENERATED CLAIMS:**
  I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

  _____
  (Service Center Preparing Invoices)

  Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

  Prior service center code: _____

- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105

First Health
Services Corporation

Fiscal Agent for Virginia's Medical Assistance Program - Provider Enrollment Unit

Date 09/18/00

Thank you for your request to be certified as a Unit Dose System Dispenser (24-hour supply of medications dispensed daily). Additional reimbursement(s) for unit dose packaged products is available once the Department of Medical Assistance Services has certified the pharmacy as a unit dose dispenser and if the recipient is certified as a skilled or intermediate care patient. Each dose of medication must be individually packaged in a unit dose container that is a single unit container for articles intended for administration by other than the parenteral route as a single dose, direct from the container. The unit dose package is then placed in the patient's bin or drawer which is labeled only with the patient's name and location and delivered daily to the nursing home to qualify for unit dose dispensing.

Type or print the information requested below.

Pharmacy Name _____ Medicaid # _____

Physical Address _____ Telephone # _____

City, State, Zip _____

I. Be advised this pharmacy provides unit-dose pharmaceutical services to the following listed nursing home facilities:

	Name of Facility	Address
1.		
2.		
3.		
4.		
5.		
6.		

II. The unit-dose system utilized by this pharmacy is known commercially as _____.

III. Currently, the following dosage forms are provided in unit-dose packages:

Type	Yes	No	Type	Yes	No
Capsules and tablets			Suppositories		
Oral liquids			Others _____		
Others _____			Others _____		

IV. Submitted by: Name Position Date

V. I certify that _____ Pharmacy **agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**

(Signature of Owner or Official) (Date)

Official Use ONLY: Approved ☐ Denied ☐ Signature: _____ Date: _____